Expressions ORTHODONTICS

Fort Orthodontics

Dr. Sunny Leong, DDS, DIP. ORTHO, F.R.C.D. (C)
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REFERRING OFFICE INFO

Referring Dr. ______________________________ Date: MM / DD / YY

Phone: ______________________ Email: ______________________

○ our practice requires more referral pads

PATIENT INFO

Preferred Location: ○ Expressions Orthodontics ○ Fort Orthodontics

Patient Name: FIRST NAME ______________ LAST NAME ______________

Birthdate: MM / DD / YY Age: ________

Parent/Guardian Name (if applicable): FIRST NAME ______________ LAST NAME ______________

Email: ______________________________

Cell: ______________________ Other (home/work): ______________________

Orthodontic Coverage: ○ Insurance ○ None ○ NIHB ○ ADSC

1. Insurance Company: ______________ Plan #: ________ ID #: ________

Subscriber Name: ______________ Subscriber DOB: MM / DD / YY

2. Insurance Company: ______________ Plan #: ________ ID #: ________

Subscriber Name: ______________ Subscriber DOB: MM / DD / YY

Reason for referral: ○ Specific Concern (please specify): ______________________

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Date of last exam and hygiene appointment: MM / DD / YY

RADIOGRAPHIC INFO

Radiographs: ○ Panoramic (Date Taken MM / DD / YY)

○ None ○ Emailed (info@expressionsortho.com, info@fortortho.com) ○ Mailed ○ With Patient

Your confidence in our practice is appreciated.
We look forward to welcoming your patient in our office.
See the flip side for directions.

Visit us online at: expressionsortho.com | fortortho.com